DOCUMENT RESUME

ED 275 919 CG 019 451

AUTHOR Keener, Dana Ray
TITLE Is Changing Sexual Orientation a Viable Option for Ego-Dystonic Homosexuality?
PUB DATE Aug 86
NOTE 69p.; Doctor of Psychology Research Paper, Biola University, California.
PUB TYPE Information Analyses (070)

EDRS PRICE MF01/PC03 Plus Postage.
DESCRIPTORS Attitude Change; Behavior Change; *Behavior Modification; *Group Therapy; *Homosexuality; Life Style; *Psychotherapy; *Self Help Programs; *Sexual Identity

ABSTRACT

This paper addresses the issue of homosexuals who want to change their sexual orientation. It is noted that many ego-dystonic homosexuals who want to become heterosexual, despite encouragement from psychotherapists to accept their homosexuality, are turning to self-help groups in an effort to change their sexual orientation. Studies that have attempted to change sexual orientation are reviewed in this paper. Problems with defining and measuring change in sexual orientation are considered and the importance of therapies for changing sexual orientation is discussed. Studies involving psychoanalytic therapies are reviewed. Several studies on behavior therapies are examined, including studies of aversion therapy, classical conditioning, and systematic desensitization. Studies dealing with group therapy are discussed under the headings of heterogeneous groups, homogeneous groups, and self-help groups. Problems associated with each type of therapy are noted. The paper concludes that studies in which changes in sexual orientation seem most complete involve a change in lifestyle whereby the person takes on a new social and sexual identity. It is asserted that psychotherapists can offer better help to homosexuals desiring to change their sexual orientation as aspects of sexual identity and lifestyle are more fully addressed. (Author/NB)

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ED275919

IS CHANGING SEXUAL ORIENTATION A VIABLE OPTION FOR EGO-DYSTONIC HOMOSEXUALITY?

CG 019451

Doctoral Research Paper for
the Degree of Doctor of Psychology

ROSEMEAD SCHOOL OF PSYCHOLOGY

BIOLA UNIVERSITY

DANA RAY KEENER

1986

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IS CHANGING SEXUAL ORIENTATION A VIABLE OPTION FOR EGO-DYSTONIC HOMOSEXUALITY?

BY

DANA RAY KEENER

A doctoral research paper submitted to
Rosemead School of Psychology
in partial fulfillment of the requirements
for the degree of
Doctor of Psychology

La Mirada, California

1986

IS CHANGING SEXUAL ORIENTATION A VIABLE OPTION

FOR EGO-DYSTONIC HOMOSEXUALITY?

BY

DANA RAY KEENER

APPROVED:

Robert E. Langsley Date 8/18/86
First Reader

Gary N. Strauss Date 8/18/86
Second Reader

APPROVED:

Bruce Kennedy, Ph.D
Dean

8/18/86
Date

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Abstract

This paper reviews studies that attempt to change sexual orientation. Although there are many problems with defining and measuring change in sexual orientation, the literature indicates that many homosexual persons desiring to change their sexual orientation can do so with treatment. Ego-dystonic homosexual persons continue to seek help in becoming heterosexual despite increased encouragement from psychotherapists for them to accept their homosexuality. Many homosexuals desiring to change their sexual orientation are turning to self-help groups. This paper asserts that psychotherapists can offer better help to homosexuals desiring to change as aspects of sexual identity and lifestyle are more fully addressed.

Is Changing Sexual Orientation a Viable Option for Ego-Dystonic Homosexuality?

> Therapy for homosexuals who want reorientation is a controversial topic, particularly since in some areas of the country, the gay population is finally being allowed to live without high levels of public predjudice. However to ignore the goals of clients who want to change their preference is both paradoxical and prejudiced (Schwartz & Masters, 1984, p. 180).

According to Schwartz and Masters, the paradox is that homosexual persons are given the message that they have to live with their homosexuality while the clinical evidence indicates that sexual orientation is changeable.

Over the past decade the prominent public view has been that homosexual persons cannot change their sexual orientation to any significant degree. This view has been perpetuated by the gay liberation movement. The media has focused on stories about the problems homosexual persons face in "coming out of the closet" (Church, 1979; Kantrowitz, Greenberg, McKillop, Starr & Burgower, 1986; Leo, Hopkins, McIntosh, & Brine, 1975; Reese & Abramson, 1986; Roderick, 1984a, 1984b). Little, if anything, has been written on the struggles of those homosexual persons wanting to change their sexual orientation. In previewing Masters and Johnsons' book, Homosexuality in Perspective, Galvin (1979) expressed suprise at their finding that over 60% of those homosexuals wanting to change their sexual orientation did so in the Masters and Johnson program.

It is difficult to determine how many homosexual

persons are interested in changing to heterosexuality. Even estimates of the size of the homosexual population in the United States vary from 3% to 10% of the total population. This would include roughly 6 to 20 million people (Crooks & Baur, 1980; Leo et al., 1975). It is uncertain how many of these people wish to change to heterosexuality. The number of persons requesting therapy for such change is rather small. Masters and Johnson report only 67 homosexuals requesting to enter their program to change sexual orientation between 1968 and 1977 (Galvin, 1979). Many of the studies on sexual orientation change are case studies or use a small number of subjects.

However, if we look at self-help groups for persons wanting to become heterosexual, we get a different picture. Pattison and Durrance (1985) reported that these self-help groups, such as Homosexuals Anonymous and various "Ex-Gay" programs, exist in at least 30 U.S. cities as well as England, France, Africa, Brazil, Australia, and elsewhere. Pattison and Pattison (1980) studied one of these self-help groups that was sponsored by a pentecostal church. Over a five-year period, 300 persons entered this program seeking to become heterosexual. In a newsletter printed by Desert Stream, another self-help group sponsored by the Vineyard Christian Fellowship which is located in the Los Angeles area, Davis (1985) claimed that they were providing weekly counseling for approximately 45 people leaving the homosexual lifestlye. Because of the increasing number of

people seeking help, Desert Stream is in constant need of more staff. They desire more help from people who are professionally trained.

From the above information it seems that persons desiring to change their sexual orientation are turning toward those resources that are offering the most hope and help. As it has become popular in psychological circles to downplay or reject a person's desire to change sexual orientation it is no wonder that these people have turned elsewhere. If people do not believe that psychotherapy will help them they will not turn to psychotherapists for help.

In recent years much of the attention of psychology has been directed away from looking for more effective therapies for helping homosexual persons to change their sexual orientation. Instead, the focus has been on the controversy of whether homosexual persons should attempt to change their sexual orientation and, more importantly, whether psychotherapists should help them in such attempts. On one side is the view that homosexuality is a pathological sexual orientation in need of change. The other side is the view that homosexuality is a variation of normal sexual expression. This second view concludes that the only problems of homosexuality are those caused by the attitudes of society and that it is society that needs to do the changing.

Prior to 1960 homosexuality was largely viewed as a pathological syndrome associated with neurotic patterns.

Much of the research of the 1960's focused on whether homosexuals exhibited more pathology than non-homosexuals. In a review of the research on homosexuality prior to 1966, Miller, Bradley, Gross and Wood (1968) leaned in the direction that homosexuality is not an outgrowth of neurotic patterns. They proposed that "a legitimate therapeutic goal could be the elimination of current discomforting symptomotology without the necessary elimination of the homosexual behavior" (p. 3). This view gained momentum and in 1973 a vote by the American Psychiatric Association removed homosexuality from its list of mental disorders.

This decision to remove homosexuality from the category of pathology was far from universally accepted by psychiatrists and psychotherapists. Many reacted to the political nature of the decision and to having such a change determined by popular vote (Ferleman, 1974).

Although the popular view that homosexuality was not a pathology has continued to prevail, the voice of dissension has also been heard heard. The controversy led to a new diagnosis, "ego-dystonic homosexuality," in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, Third Edition (DSM III) in 1980. It applies when (1) the individual complains that heterosexual arousal is persistently absent or weak and significantly interferes with initiating or maintaining wanted heterosexual relationships and (2) there is a sustained pattern of homosexual arousal that the individual

explicitly states has been unwanted and a persistent source of distress. This category is for those homosexuals "for whom changing sexual orientation is a persistent concern" (p. 281). Ego-syntonic homosexuality, that which is accepted or desired by the individual, is not included in the DSM III as it is seen as a normal variant of sexual expression. Gone are the days when homosexuality was universally seen as deviant, pathological, and criminal where the homosexual person is coerced into attempting to change. The current controversy centers on whether persons with ego-dystonic homosexuality should be helped to change their sexual orientation or helped to accept their homosexuality.

Morin (1977) proposed that if homosexuality per se is not indicative of pathology, then we should not try to change a homosexual orientation or even include it as a diagnosis. Davison (1976, 1978) carried this point even further insisting that the pressure for homosexuals to change their sexual orientation is external and we can never be certain that such a desire is voluntary. He suggested that people should first be desensitized of all guilt and shame about their homosexuality and then see if they are still motivated to change. His implication was that no one would want to change if these pressures to change were removed. For Davison, to offer therapy for change of sexual orientation is to label homosexuality as pathological. It becomes an ethical issue, not an issue of whether change is

possible.

Bieber (1976) and others who continue to view homosexuality as pathological responded that society may not be so readily convinced of the normality of homosexuality. Bieber contended, in stark opposition to Davison, that those homosexuals who do not want to change are just not aware of their desire to do so. He pointed out that people seek change when the possibility exists. Along with Socarides and Voth, he believed it to be a "grave error" not to provide services to persons wanting to become heterosexual and to deprive people in need (Ferleman, 1974).

In responding to Davison, Sturgis and Adams (1978) proposed a third and more moderate view about helping people to change their sexual orientation. They asserted that whether homosexuality, or any behavior, is normal or abnormal is irrelevant to whether a therapist should respond to a client's desire to change. Gonsiorek (1982) agreed with this more neutral view:

> The client may have a belief that one sexual orientation is preferable for him or her. As long as this is based on a reality-oriented appraisal by the client of him or herself, a realistic appraisal of the challenges inherent in either choice, and the choice is ego-syntonic, it is probably more therapeutically efficacious to honor this choice. Therapists who have an axe to grind about sexual object choice with these clients may put an additional roadblock in their already difficult task. (p. 15)

Because of the difficulty of the task as well as the controversial nature of such a decision, both Halleck (1976) and Gonsiorek agreed with Davison in stressing the need to

carefully ascertain a homosexual person's motivation to change to heterosexuality.

Some realistic concerns have been raised about change-of-orientation therapies. One concern is that the client may be hurt more than helped if the goal is not reached. Some clients may enter therapy with the belief that changing sexual orientation will solve all of their problems. Such an unrealistic expectation may leave them in despair even if change is accomplished. Sometimes as a person becomes more heterosexual they marry and even have children. If such persons revert to homosexuality it can bring harm to a spouse and family (Davison, 1978; Hetrick & Martin, 1984).

Methodological Problems

Definition of Homosexuality

We speak of homosexuality and heterosexuality, and indeed some see sexual orientation as dichotomous. Altshuler (1984) sees bisexuality as a way-station toward either a homosexual or a heterosexual orientation. However, the majority of researchers and therapists agree with the observation of Kinsey, Pomeroy, and Martin (1948) that sexual orientation is best described by a continuum. To assess the degree of sexual orientation, Kinsey devised a scale which continues to be used in research. On this seven-point scale a rating of 0 is defined as exclusivly heterosexual while a rating of 6 is exclusively homosexual.

Although widely accepted, the Kinsey scale is not

complete. Gonsiorek (1982) explained that, in spite of its usefulness, the Kinsey continuum does not capture the complexity of the problem of defining sexual orientation. Coleman (1978) saw the shortcoming of the Kinsey scale as its focus on overt behavior for evaluating sexual orientation. He suggested that one cannot assume that a change in behavior reflects a change in orientation, fantasy or attitude because these are not always congruent. Coleman asserts that fantasy is probably the best indicator of an individual's sexual orientation because of suppressor variables that influence behavior. Schwartz and Masters (1984) agreed that fantasy is one specific diagnostic criterion of sexual orientation but not the main one. Labeling a person homosexual has generally been based on same-sex attraction, same-sex experience, and same-sex fantasy, but they asserted that none of these have been established as empirically valid. They proposed that the only logical criterion for classification of a homosexual orientation is "preference for same-sex romantic and sexual consorts" (p. 174). This is in agreement with the traditional psychoanalytic definition as presented by Socarides (1968) where homosexuality was seen as the choice of an object of the same sex for orgastic satisfaction.

As we look at the various aspects of homosexuality, including overt behavior, fantasy, attitudes, sexual attraction, and sexual preference, all of which vary along a

continuum, we gain an understanding of the complexity of defining homosexuality. Different studies use different measures based on which aspects they include in their definition. This makes comparing studies difficult and creates problems in defining when change has occurred.

Definition of Change of Sexual Orientation

Viewing sexual orientation as a continuum makes it difficult to determine at what point one changes from a homosexual to a heterosexual orientation. How much change in behavior has to occur before one moves from homosexuality to heterosexuality? How often does a person have to experience heterosexual fantasies to be considered heterosexual? By changing the criteria for sucessful change of sexual orientation, the same study can be used to argue for or against the ability of therapy to help in changing sexual orientation.

Schwartz and Masters (1984) pointed out that because of the lack of clarity in defining change in sexual orientation, the significance of changing to a heterosexual orientation can be downplayed with the interpretation that the person was not really homosexual in the first place. Another aspect of this problem is that by choosing change in sexual behavior as the criterion, it makes the goal easier to reach. Hetrick and Martin (1984) reported that one result of confusing the sexual act with sexual orientation is that all therapies attempting to change sexual orientation report efficacy in terms of sexual behavior. They strongly

disagree that marriage is any demonstration of heterosexual orientation as many homosexual persons are married and have families.

Pattison and Durrance (1985) indicated another problem in measuring change in sexual orientation. Of people who had changed from homosexuality to heterosexuality, some reverted back, some remained heterosexual, and some fluctuated back and forth. No change in sexual orientation can be considered permanent. Based on observations of other cultures, men in prison, and the changing sexual orientation of many adolescents, it appears that any sexual orientation is capable of changing in a variety of circumstances (Pattison & Durrance, 1985; Schwartz & Masters, 1984).

Sexual orientation seems to be less permanent than is often assumed. This possibility for spontaneous fluctuations as well as the complexity of defining a person's sexual orientation makes it difficult to define change in sexual orientation with any certainty. It also makes it difficult to determine how long the change must last to be considered significant.

Sexual Identity

Another problem in defining homosexuality, and therefore change in sexual orientation, is that homosexuality involves more than just sexual orientation in most cases. It often involves an identity with a particular social group and a certain sense of one's own uniqueness as

an individual and the intrapsychic processes that support that sense (Hetrick & Martin, 1984). Bell, Weinberg, and Hammersmith (1981) also believed identity to be strongly linked to sexual orientation. Herron, Kinter, Sollinger, and Trubowitz (1982) asserted that sexual orientation is a part of one's sexual identity which also includes biological sex, gender identity, and social sex role. The interaction between these various aspects of sexual identity creates great diversity between persons who all consider themselves homosexual.

Importance of Therapies for Changing Sexual Orientation

Whether one agrees with those who view homosexuality as pathological or with those who stress that homosexuality is not a pathology, the reality is that there are homosexual persons asking for help in changing their sexual orientation. Such clients do not want therapy designed to improve their homosexual functioning (Paul, Weinrich, Gonsiorek & Hotvedt, 1982). Should we do as Davison (1976, 1978) suggested and refuse to help them in changing their sexual orientation, insisting that they accept their homosexuality, or do we heed the advice of Schwartz and Masters (1984) that not to offer them help is prejudice? From the growth of the self-help movement it appears that homosexual persons desiring change are going to seek help where it is offered. This confirms Bieber's (1978) belief that people seek change when the possibility exists.

Psychology has seen the pendulum swing from the view that homosexuality is pathology and all homosexuals should be treated to the view espoused by the gay liberation movement that changing sexual orientation is not an option. Maybe it is time to take a realistic look at the needs of people. People are looking elsewhere for help because the doors of psychotherapy are closing. The reality is that some homosexuals have a genuine desire to change. Society is changing its view toward homosexuality but not that quickly or pervasively. Although acceptance of gays is growing, a nationwide poll conducted by the Los Angeles Times found that 52% of the people still oppose the homosexual lifestyle, even for others (Roderick, 1984a). The recent problem of AIDS has increased prejudices within society and fear within many homosexuals. Some homosexual persons are caught between their sexual orientation and their religious belief that homosexuality is not acceptable (Pattison & Pattison, 1980). Others are torn between their homosexuality and acceptance from people who are very important to them and their mental health. It is very difficult to sort out which of these motivations to change are from external pressure and which are from internal pressure. It appears that even if society could change, there would still be homosexuals desiring to change.

The purpose of this paper is to assess the ability of therapy to help these persons who want to change their sexual orientation. If change is possible with psychotherapy, which

are the most helpful therapies with the best chances for success? This paper will evaluate research in this area in an attempt to provide some answers to this question.

Psychoanalytic Therapy

There are various psychoanalytic or psychodynamic theories on the causation of homosexuality, all of which involve a developmental conceptualization of its etiology. Psychoanalytic therapy is one of the older therapies and therefore was one of the first to deal with the issue of homosexuality.

Although psychoanalysis was the first therapeutic hope offered to homosexuals wishing to change, Mayerson and Lief (1965) wrote that it has only been since the 1940's that psychiatrists have considered that patients with homosexual problems could be treated by psychotherapy. A rather skeptical report of early therapeutic change was delivered by the authors of the Wolfenden Report in 1957 which recommended the relaxation of the English criminal law against adult homosexuality. After reviewing reports of change from homosexuality to heterosexuality they remarked in paragraph 193:

> We were struck by the fact that none of our medical witnesses were able when we saw them, to provide any reference in medical literature to a complete change of this kind. Some of them have since sent us one or two examples in which such change is claimed, but it is extremely difficult to assess the results in such cases. (Committee on Homosexual Offenses and Prostitution, 1963, p. 110)

During this same time in the United States, however, the literature began to present reports of successful treatment of homosexuality. West (1977) wrote that in 1956 Albert Ellis reported on the outcome of psychoanalytically oriented therapy with 28 men and 12 women with "severe" homosexual problems. Eight of the women and 11 of the men were "considerably improved," defined as beginning to lose their fears and to enjoy amorous relations with the opposite sex. Previous heterosexual experience indicated a better chance of success.

Cappon (1965) asserted that in his treatment of persons for sexual problems, 80% of homosexuals were markedly more heterosexual and 50% were fully heterosexual. Of bisexuals who completed treatment, 90% became heterosexual with no reversion to homosexual desire or behavior. West (1977) believed this to be an absurd extreme in claiming success.

West reported more modest claims by Curran and Parr in 1957 and Woodward in 1958. Curran and Parr reported that of 24 exclusively homosexual men only one changed toward heterosexuality. Of 28 men who were bisexual or only partially homosexual, eight changed toward heterosexuality and three became homosexual. Woodward similarly reported no change among those who were exclusively homosexual.

In a fairly conscientious study, Mayerson and Lief (1965) followed up on 19 former patients, 14 men and five women, after an average of four and a half years following

completion of therapy. The average length of therapy for these clients was 1.7 years. Two of the nine patients originally considered exclusively homosexual had become substantially heterosexual in behavior. Seven of the ten who had originally been bisexual or partially homosexual patients had become heterosexual.

Much of the literature on the results of psychoanalytic treatment is in the form of case studies. These case studies are most often included as examples and illustrations in books written about theories of the development of homosexuality and corresponding treatment. Ovesey (1969) wrote such a book explaining his view of homosexual etiology. He included three case examples to illustrate his theory and to demonstrate how he had successfully treated their homosexuality. This success was based on his clinical observations and the fact that they were married and raising families at a followup of five years or more.

Another such example is Homosexuality by Socarides (1978) which includes various case studies which are considered to be more or less successful. Success was defined by many of these psychoanalytic case studies as any change toward heterosexuality. Naiman (1968) reported a case study in which analytic interpretations had helped the client begin to change in behavior and reported dream material toward heterosexuality. While he viewed this as success, he agreed that much work remained.

Bieber (1962) recognized the weakness of the case study approach in that it did not allow for statistical analysis. He also recognized the value of the case study to the psychoanalytic therapist in providing insight into the uniqueness of individual personality and behavioral dynamics. His 1962 book, Homosexuality, A Psychoanalytic Study, was an effort to make the most of the case study. He collected data on 106 men who had been homosexual or bisexual prior to psychoanalysis. Twenty-nine, or 27%, of the 106 had become exclusively heterosexual during the course of analysis. Of the 76 who had been exclusively homosexual, 14 became heterosexual and of the 30 men who were initially bisexual, 15 became exclusively heterosexual. THe criteria for homosexuality and heterosexuality were not specified but it appeared to include sexual behavior, fantasy and sexual attraction as reported by the client.

Mitchell (1981) questioned several of these psychoanalytic authors (Bieber, Ovesey, Socarides, and Hatterer) concerning their therapeutic approach. Mitchell stated that their more directive approach of actively encouraging heterosexual behavior and discouraging homosexual behavior is a serious departure from the traditional analytic position of neutrality. This suggestive-directive approach has been the most dominant approach in treating homosexuality although it is practiced

by only a minority of psychoanalysts. Mitchell wrote:

> Most psychoanalysts approach homosexual material produced by their patients as they would any other experiences of their patients--simply as material to be inquired into and analyzed. Such analysts are not likely to write about psychoanalytic approaches to treating homosexuality since they would tend to feel that homosexuality does not pose particularly destructive or unique features in terms of analytic work. (p. 63)

Anna Freud emphasized this point of not changing from usual psychoanalytic technique when working with homosexual patients during a panel discussion involving Arlow, Freud, Lampal-De Groot and Beres (1968). She stated that one of the reasons for this is the diversity of many aspects of homosexuality, she did not consider it one kind or type. In that same discussion she stressed the importance of the client's desire to change if change is to take place.

Mitchell (1981) stressed this idea that chances for success are minimal if the patient has no interest in changing sexual orientation. He traces this belief back throughout the analytic literature as far as Sigmund Freud. Mitchell presented that a serious problem results when clients change for the sake of the therapist instead of their own desire to change. This is more likely to happen in a directive-suggestive approach to therapy. Mitchell described a client who changes sexual orientation to gain the approval of the therapist as a pseudoheterosexual, someone who appears to be heterosexual but is not satisfied with his or her sexual orientation.

Mitchell (1981) presented a case study of such an

individual who had been in therapy previously, changing from homosexuality to heterosexuality in his behavior. The client came to Mitchell after several years because of his dissatisfaction with heterosexuality. Many former issues were dealt with, including his anger at the previous therapist for his strong expectation for the client to change. At the completion of therapy with Dr. Mitchell, the client chose to remain heterosexual but felt more resolved and satisfied with his own choice of heterosexuality.

Van Den Aardweg (1972) presented a rather optimistic rate of success with an unorthodox psychotherapy which he calls "exaggeration therapy." He proposed that homosexuality is a variant of neurosis. The central issue is one of self pity, resulting from the client's belief that he or she is inferior and pitiable. The healing effect of exaggeration therapy comes from pointing out the lack of validity and ridiculousness of self pity rooted in childish complaints. Humor plays a central role. If clients are laughing at themselves, they cannot complain at the same time. The defensive mechanism of complaining and self pity is destroyed and associated symptoms such as homosexuality are relieved. Van Den Aardweg reported that in applying this therapy to 70 homosexuals, 20 treatments had been completed. Of those 20, he considered 10 to be "real cures" and the other 10 as improved. In the improved cases the clients were satisfied enough with their success to stop

treatment. He described a cure of homosexuality as "the extinction of homosexual impulses (feelings and fantasies) and the restoration of normal ones, for an extended period of time" (p. 63). In his study this period was from one to seven years.

Problems With Psychoanalytic Therapy

A major problem is that all of these criteria for change were measured by the therapist using clinical judgement, by client self-report or both. All of these are subjective measures and constitute a weakness of analytic research on sexual orientation change. A related problem is that most analytic research does not take into account the degree of homosexuality or the degree of change in sexual orientation. This is important in determining efficacy of treatment, as the general agreement seems to be that the more homosexual a person is rated, the more difficult it is for that person to change to heterosexuality.

While the extended length of most analytic therapies may also be criticized, it does allow for a more complete understanding of the client's sexuality on the part of the therapist. Extended periods of follow-up, where the clients are often evaluated several years later, are a strength of some analytic studies.

Summary of Psychoanalytic Therapy

A consistent theme throughout the history of psychoanalytic therapy is that a change in sexual orientation is much more likely if the client has a desire

to change. Mitchell (1981) stressed that not only must the desire to change come from the client, but also the therapist must make no demands for change. Otherwise the client may change in order to please the therapist and gain the therapist's acceptance. Such change is not likely to be satisfactory to the client. Both Van Den Aardweg (1972) and Mitchell stressed the importance of change being internal, including a change of fantasies and feelings, not merely behavioral change. Many researchers were satisfied to use behavior as a measure of change. Another measure used was a decrease in anxiety about heterosexual relations which allowed the client to enjoy heterosexual relationships. An often criticized criterion of change was that of marriage and children.

From the literature reviewed it would appear that psychoanalytic therapy can help some homosexual people change their sexual orientation. It appears to be most useful for those people with a strong desire to change and who have had some prior heterosexual experience. How much change is possible and how much more effective it is than no therapy at all are questions that remain to be answered.

Behavior Therapies

Behaviorally oriented therapies operate from the theory that sexual behavior, and therefore homosexual behavior, is learned. What has been learned can be unlearned and new

behaviors can be taught to the client. Many early behavior therapists working with homosexual problems focused on the unlearning or extinction of the unwanted behavior. This aversion therapy was initially considered the most effective approach to dealing with homosexual problems.

Aversion Therapy

The earliest aversion therapy for homosexuality in the 1960s was patterned after aversive treatment for alcoholism. A drug, apomorphine, was used to produce nausea. The client would then be exposed to visual homosexual stimuli. When the nausea began to subside the stimuli would be taken away. This was a very complicated and arduous procedure (Feldman & MacCulloch, 1971).

McConaghy (1971) compared apomorphine treatment with aversion relief and avoidance learning. In aversion relief therapy the client was given a shock while watching a slide of a word or phrase that was homosexually evocative to the client. Following the shock, the client saw a slide of heterosexual material for 40 seconds. The appearance of this slide provided a sense of relief as the client learned it would not produce shock.

In avoidance learning the client controlled the length of time he viewed a slide of a male nude. After viewing the slide for eight seconds he would recieve a shock. The shock continued until he removed the slide.

McConaghy used changes in penile volume to determine the effectiveness of treatment as this had been shown to

reliably differentiate between homosexual and heterosexual males viewing erotic films (McConaghy, 1970). He found no significant differences between the three forms of aversive therapy. At a one-year follow-up half of the clients reported heterosexual feelings and half, not necessarily the same half, reported a decrease in homosexual feelings. No indication was given as to the degree of this increase or decrease of sexual feelings. Since no control subjects were used in this study, changes that did take place could be due to confounding variables. This study did not address whether these forms of aversive therapy are any better than no therapy.

Because of the problems with chemical aversion and the fact that its effectiveness was no better than other methods, electrical shock became the preferred method of aversive treatment. Studies began to focus on improving aversion therapies using electrical shock. Tanner (1973) used change in penile circumference to measure the effect of different intensities of electrical shock on the modification of homosexual behavior by avoidance learning. He concluded that shock intensity influenced the effectiveness of avoidance training. If the electrical current is not intense enough, learning may not occur. If the shock is too intense, subjects may avoid the treatment altogether and drop out of the program.

Tanner (1974) was concerned that no studies had ever

demonstrated directly that avoidance training was better than no treatment at all in changing homosexual behavior. He did a fairly comprehensive study comparing a waiting list control group to an avoidance training group. Each group included eight men. He found a significant difference between groups on six of twelve measures. These included a decrease in penile volume while viewing male slides, self reported reduction in arousal while viewing male slides, an increase in frequency of sex with females, increased socialization with females, and a change toward heterosexuality as measured by scale five on the Minnesota Multiphasic Personality Inventory. Although the overall difference between groups was significant on these measures, individual changes did not always appear to be great enough to be meaningful for each man.

Early work by Feldman, MacCulloch and others using avoidance training was criticized because their method of treatment did not allow subjects to escape from the aversion whatever their response (MacDonough, 1972). This criticism seemed to guide Sambrooks, MacCulloch and Waddington (1978) toward studying the effectiveness of anticipatory avoidance aversion therapy for homosexuality. This treatment allowed the subject to anticipate the aversive element of therapy, such as electrical shock. By responding with heterosexual behavior the aversive element could be avoided. Sambrooks et al. used anticipatory avoidance aversion therapy with two homosexual men. Twenty-five treatments were given at weekly

intervals. Both within-session and between-session measures were recorded. They noted that during sessions 12-25 the greatest amount of improvement took place between the treatments. In fact there seemed to be some unlearning of sexual avoidance of males taking place during the sessions. They concluded that in cases where increases in the between-treatment response of sexual avoidance of males exceeded the rate of extinction of those responses, whether during or between treatments, the treatment succeeded.

In another article further examining this same research, MacCulloch, Waddington and Sambrooks (1978) measured how long the subject would look at a homoerotic slide under threat of electrical shock. Shock could be avoided altogether if the subject changed slides within eight seconds of presentation. They reported finding a significant correlation between this avoidance latency and another measure of sexual attitude change, the Sexual Orientation Method.

The Sexual Orientation Method (SOM) was designed by Feldman and MacCulloch (1971) in an attempt to improve on the Kinsey rating of the degree of homosexuality or heterosexuality. They saw the Kinsey rating scale as overly subjective because it was based on a clinical interview. The SOM is a rather complicated technique based on responses to a questionnaire reported to measure sexual attitudes. Responses to the SOM are graded onto an eight-point scale

allowing for a continuum of scores on both a homosexual and a heterosexual scale. A client is given a score on each scale and these scores can vary independently of each other. A score of 48 represents maximal interest and a score of six, minimal interest.

MacDonough (1972) reported finding many inconsistencies in scoring by researchers using the SOM. He criticized the SOM for being too subjective, the very problem it was designed to overcome. However, the SOM did seem to be a step in the right direction. It attempted to take each individual's attitudes and desires into consideration, not just measure the clients' behavioral and physiological responses.

Throughout the research on aversion treatment for homosexuality, the emphasis seemed to be on technique and not on the treatment of persons. The assumption seemed to be that the treatment will work if properly applied. One response to treatment failure was to place the blame on the client for the client's other psychological problems or for having a "weak willed" or "attention seeking" personality (MacCulloch et al., 1978; Tanner, 1973).

Wilson and Davison reported in 1974 that aversion therapy was the most commonly employed behavioral treatment for reducing homosexual behavior and thoughts. Aversion therapy focuses on training the client to avoid homosexual thoughts and behavior but offers no help toward becoming heterosexual. The assumption seems to be that if homosexual

behavior and attitudes decrease, heterosexuality will develop. This does not always appear to happen and additional treatment seems to be required.

Classical Conditioning

Whereas aversion therapies attempt to eliminate unwanted behavior, classical conditioning attempts to develop new behavior. This is accomplished by pairing heterosexual stimuli with already attractive homosexual stimuli. As the person becomes more attracted to the new heterosexual stimuli it elicits sexual responses that are increasingly heterosexual.

Freeman and Meyer (1975) decided that the problem is not the sexual response but the stimulus that elicits the response. Before using aversion techniques to eliminate responsiveness to homosexual stimuli they first used classical conditioning to help the client become more aroused to heterosexual stimuli. During treatment the clients moved through a bisexual stage toward heterosexuality.

They used this treatment for 11 male subjects rated exclusively homosexual by the Kinsey scale. After 20 treatments over a 10-week period all 11 remained free of homosexual behavior for one year. At an 18-month follow-up nine continued heterosexual adjustment while two were involved in homosexual relationships. These failures were attributed to environmental stress and in-vivo reconditioning by a homosexual companion. Both self-report and physiological measures were used. Follow-up after 18

months increased the credibility of this study.

Herman, Barlow and Agras (1974) conducted a study using only classical conditioning as a method of increasing heterosexual arousal in three homosexual males. Three measures of change were recorded. One was change in sexual urges and fantasies as recorded in a diary by the client. The Sexual Orientation Method was also used to assess changes in homosexual and heterosexual orientation. The third measure was change in penile circumference in response to slides of nude males and females.

For two of the clients there was considerable increase in heterosexual responsiveness on all three measures. However, there was little decrease in homosexual arousal. The third client demonstrated little change, maintaining a response pattern characterized by maximum responding on all homosexual measures and near zero responding on all heterosexual measures. The authors expressed suprise at this lack of change in view of the two successes but concluded that it was an indication of individual differences between homosexual persons.

Feldman and MacCulloch (1971) compared the effectiveness of classical conditioning, anticipatory avoidance learning and psychotherapy with a group of 43 homosexual men. The Sexual Orientation Method was used to measure the degree of change in sexual orientation. They concluded that both classical conditioning and anticipatory

avoidance learning were unsuccessful with primary homosexuals (no prior heterosexual experience) and that both were relatively successful with secondary homosexuals (prior heterosexual experience) in helping to change sexual orientation. Futhermore, they concluded that both were superior to psychotherapy. They conceded that this may be attributed to a time factor. Psychotherapy may have increased in effectiveness if therapy had continued beyond the length of their study. They proposed that the most effective treatment may be a combination of classical conditioning and anticipatory avoidance learning. This was a recognition of the complexity involved in changing sexual orientation.

Systematic Desensitization and Orgasmic Reconditioning

Other behavioral techniques were added to the repertoire of behavioral approaches used in dealing with the complexity of homosexuality. Hanson and Adesso (1971) recognized that homosexuality has multiple components requiring treatment of these various components. They presented a case study involving a 23-year-old male who was homosexually active. Their 14-week treatment had four components. They used systematic desensitization to reduce heterosexual anxiety. Electrical aversive counter conditioning was used simultaneously to reduce the attraction value of homosexual stimuli. Masturbation training involved switching from homosexual to heterosexual fantasies. The client was encouraged to always ejaculate

on a heterosexual fantasy but to revert as needed to maintain an erection during masturbation. The final part of therapy was in-vivo training where the client had to find a suitable dating partner with whom he could practice heterosexual skills and further reduce anxiety. He considered himself "cured" after 14 weeks when he was able to engage in sexual intercourse. Therapy was terminated at this point. A six-month follow-up indicated that his heterosexual interest continued to increase while his homosexual arousal remained at consistantly low levels. While this treatment is more comprehensive, the conclusions to be made are limited because it is only one client and the measures of success were based on self report.

Conrad and Wincze (1976) emphasized problems of measurement, especially reliance on self report, in their study of orgasmic reconditioning. Orgasmic reconditioning is basically the same as the masturbation training used by Hanson and Adesso (1972) except that visual stimuli were used to help the client fantasize during masturbation. Conrad and Wincze used both physiological (penile circumference) and self-report measures.

All four of the men in this study reported an increased interest in women and increased arousal to heterosexual stimuli. However, none of the men demonstrated any change in physiological arousal. This may have been due to low levels of penile circumference initially due to anxiety

caused by the laboratory environment. One client reported a temptation to fake favorable responses in his self reports in order to convince the experimenter that treatment was progressing well. It could not be determined whether the discrepancy between measures was due to inadequate physiological measures or inaccurate self reports by all four clients. Although this study is inconclusive as to the effectiveness of treatment it highlights the problems of both self report and physiological measures of change in sexual orientation.

Problems With Behavior Therapies

Measurment seems to be the biggest methodological problem in behavioral therapy for homosexuality. Short-term physiological response measures may not predict future behavior. Self-report measures seem inadequate due to their subjectivity. The most adequate measures deal with behavior over time and changes in lifestyle. This is supported by those failures attributed to environmental or external influences. In a study of the use of booster sessions of aversion therapy 12 months after the initial therapy, Maletzky (1977) concluded that "Those who adequately change lifestyle and avoid especially provocative situations seemed to be able to derive continuing benefit from aversive conditioning without 'booster' sessions" (p. 460).

A more global problem with behavioral research is the emphasis on technique and on discovering behavioral principles at the expense of therapy. Sieveking (1972)

challenged behavior therapists to work from a behavioral framework concerning maintainance and modification of behavior and not become limited to a bag of tricks. He proposed three areas of focus when dealing with homosexual clients. The therapist must work with a series of hierarchies dealing with the areas of interpersonal problems, assertiveness, and heterosexual anxiety.

Summary of Behavior Therapies

Aversion therapy appeared to be fairly effective in decreasing homosexual behavior and arousal to homosexual stimuli. However, it did not necessarily follow that heterosexual behavior and arousal increased. In contrast, classical conditioning sometimes seemed effective in increasing heterosexual responsiveness but had little effect on decreasing homosexual arousal and behavior.

As proposed by Feldman and MacCulloch (1971), a combination of aversion training and classical conditioning seemed to be the most effective treatment. Freeman and Meyer (1975) found that a combination of the two produced significant changes in sexual orientation as rated by the Kinsey scale in all 11 male subjects. After 18 months only two had reverted to homosexual behavior.

Systematic desensitization to reduce heterosexual anxiety and orgasmic reconditioning to increase heterosexual fantasies may be helpful as adjunct techniques. However, the effectiveness of these techniques has not been fully

demonstrated in the overall change of sexual orientation.

Aversion therapy has been strongly attacked on ethical grounds. This is probably the main reason for its demise as a therapy for sexual reorientation.

The main problem with research in behavior therapies has been that of measuring change. Measures of fantasy and attitude that seem to be more representative of overall homosexual desire are criticized as being too subjective. Physiological measures which are more objective seem too narrow in their definition of homosexuality and may not predict desire or future behavior.

Group Therapy

Most group therapies operate from a developmental conceptualization of the etiology of homosexuality. Therefore group therapy is similar to psychoanalytic therapy in helping persons to change sexual orientation. Indeed some groups are defined as psychoanalytic groups. Often group members are also in individual psychotherapy or have found that individual therapy did not help them to change successfully to heterosexuality (Nobler, 1972; Rogers, Roback, McKee & Calhoun, 1976).

Throughout the literature there seemed to be two major ways in which groups differed in their approach to working with homosexual persons. The first difference was whether or not the stated purpose of the group was to help the client change sexual orientation. In some groups the

therapist explicitly stated such a goal. In others change was presented as a possibility but no pressure was exerted. In others no change in sexual orientation was expected by the therapist. The pressure to change often came implicitly through the other group members (Nobler,1972; Pitman & De Young, 1971; Rogers et al., 1976).

The other difference focused on the issue of whether it is more effective to work with homosexual persons in groups that are composed of both homosexual and heterosexual members (heterogeneous) or in groups of exclusively homosexual members (homogeneous). Usually homosexual clients entered therapy in heterogeneous groups for a variety of problems, but they entered homogeneous groups for the purpose of changing to heterosexuality. In heterogeneous groups the decision to work toward heterosexuality often came during the course of therapy (Nobler, 1972; Rogers et al., 1976).

Heterogeneous Groups

Litman (1961) discussed the treatment of a 27-year-old man in group therapy with three men and four women who were heterosexual. This client apparently had come to therapy for other problems and had no desire to change his sexual orientation at the beginning of therapy. Similar to most studies of group therapy for sexual reorientation, no assessment of the degree of homosexuality was made. Most seemed to accept Munzer's definition of a homosexual as one

who labels himself as such and who has been similarly labeled by others (Rogers et al., 1976).

Litman did not state what his goals for the client were but it appeared that the group as a whole strongly encouraged this client to move toward heterosexuality. The fact that change had taken place was based on the client's self report of his ability to have a meaningful heterosexual relationship and other behavioral changes. The success of therapy was attributed to group facilitation in discovering meaningful human relations other than homosexual relations, confrontation of reality by the group, encouragement of non-homosexual responses and group rejection of homosexual activity.

Rogers et al. (1976) cited a study by Beukenkamp in 1960 in which he reported on the treatment of a young homosexual man using combined individual and experiential group therapy. The patient apparently sought treatment after being arrested for homosexual behavior. The goal of therapy was not clearly specified but the therapist apparently had no vested interest in the client changing his sexual orientation. The other members of the group, all heterosexual, were not informed of the client's homosexuality until close to the completion of therapy. The therapist did not want the client to be stereotyped as a homosexual. After three and a half years of combined individual and group therapy the client reported that his homosexual behavior had stopped entirely and that he was

involved in a meaningful heterosexual relationship. Rogers et al. (1976) also reported on a study by Munzer in 1965. Munzer treated 8 male and 10 female homosexuals in analytic therapy groups composed mainly of male and female heterosexuals. Only 8 of the 18 claimed changing sexual orientation as a goal of therapy. Munzer reported that 5 of the 18 achieved satisfactory results from treatment. No definition of satisfactory change was given. Of the remaining members, 3 had terminated therapy prematurely and 10 were continuing in therapy. Few conclusions can be made from this study because of the lack of a definition of success and because over half of the group had not completed therapy at the time of the report.

The treatment of 10 homosexual men in heterogeneous groups was described by Mintz (1966). Each of the 10 men were in treatment for at least two years. These groups covered a 10-year period. Each group consisted of at least two homosexual clients as well as male and female heterosexual clients. All 10 subjects reported a homosexual lifestyle which included predominately or exclusively homosexual contacts for social and sexual gratification. These clients generally sought therapy for relief from anxiety or depression and not for changing to heterosexuality. Clients were assured that the therapist would make no attempts to alter their sexual orientation unless the client requested such a change. All 10 clients

were treated in combined individual and group psychoanalytic therapy. At the time of this report five had completed therapy. Two of these five reported a satisfactory heterosexual adjustment and three chose to remain homosexual. Of the five who remained in therapy, one reported a satisfactory heterosexual relationship, three reported moving toward heterosexuality with difficulty and one intended to remain homosexual. The determination of change was based on self report and the therapist's perceptions. If these reports are reliable, it would appear that anyone who chooses to change can do so to some degree with the help of group therapy. In this case the choice was made during treatment.

Pitman and De Young (1971) reported on three homosexual men and three homosexual women in group psychotherapy. Each of three therapy groups consisted of two homosexual and eight heterosexual clients with five males and five females in each group. The three homosexual men expressed a desire to change their sexual orientation. The three homosexual women began therapy for other unspecified reasons. Pitman and De Young reported that the three men achieved heterosexual adjustment. It was not specified how that was ascertained. They granted that it could be argued that these three men were not truly homosexual in that they were unhappy living as homosexuals. They contended, however, that these men are representative of homosexual men entering treatment for the purpose of change. Only one

of the women moved substantially toward heterosexuality while all were judged to have achieved their intended goals for therapy.

Various advantages have been argued for using heterogeneous therapy groups for helping clients to change their sexual orientation. Mintz (1966) used mixed groups to help dissolve defenses about the inevitability, superiority and normality of homosexuality while relieving guilt about it. The group helped to develop a stronger and broader sense of personal identity and provided a corrective emotional experience. Litman (1961) stressed the value of the group providing continuous confrontation with reality as well as group discouragement of homosexual activities and relations and encouragement of meaningful relationships not based on one's homosexuality. Munzer saw the main advantages of a mixed group being the presence of male and female heterosexual models and the denial of the client's homosexuality by the group because the client never fully fits the homosexual stereotype (Rogers et al., 1976). Pitman and De Young (1971) added that it is advantageous for the homosexual client to have close contact with heterosexual members of the same and opposite sex.

Historically there have been concerns about anxiety and animosity being directed toward homosexual group members by heterosexual members. Indeed there have been reports of heterosexual members dropping out of groups upon the

inclusion of a homosexual client. Pitman and De Young found more hostility was directed toward those homosexual clients who decided to remain homosexual than those attempting to change. Overall, however, this does not appear to be a major problem. It seems that predominantly heterosexual groups can accept homosexual clients unless the therapist is overly anxious about it (Pitman & De Young, 1971; Rogers et al., 1976).

Homogeneous Groups

Hadden (1966) reported on the progress of 32 homosexual men who were treated in groups composed exclusively of homosexual men. Twelve of these 32 clients changed to an exclusively heterosexual orientation. The criteria used to determine such change was not mentioned except that the change was client reported. It was noted that of the 12 who had changed, 2 had been married and were now finding fulfilment in marriages that had been close to divorce. Five others had gotten married and at the time of the report they had been happily married from 15 months to 5 years. The remaining 20 clients continued in therapy and were given a positive prognosis of achieving heterosexuality.

The treatment of a group of eight homosexual men by a male and female cotherapist is described by Singer and Fischer (1967). The goal of therapy for all eight clients was to change their sexual orientation. At the end of one year of psychoanalytically oriented group therapy the majority of the group members showed a significant decrease

in homosexual activity. Some were dating women on a consistent basis for the first time. As no specific measures of sexual orientation were used, the degree of change could not be determined. It was not even stated exactly how many of the eight made significant changes as determined by self report and therapists' perceptions.

Rogers et al. (1976) described a study reported by Covi in 1972 on the group therapy of 30 homosexual clients, 8 women and 22 men. These clients had entered therapy for a variety of problems and only nine men and one woman expressed any desire to change their sexual orientation prior to therapy. Of these nine, seven were under legal pressure to enter therapy. Based on presenting complaints, 18 of the clients were judged to be significantly improved. Of the 12 who did not improve, 9 had attended less than three sessions. Eight of the 18 who had improved were also considered to have made progress in terms of decreased homosexual and increased heterosexual activity. No indication was given as to the degree of progress or how the judgement of progress was made. Only one female changed in the direction of heterosexuality. This study indicates that a major requirement for effective change in sexual orientation is the client's motivation to change.

A study by Truax, Moeller and Tourney in 1970 (cited in Rogers et al., 1976) was strengthened by the use of a control group. The therapy group consisted of 20 homosexual

men and the control group consisted of 10 homosexual men. Both groups met weekly for seven months. It was not specified what the control group did during these meetings. The goals of therapy were not specified. Two self-report measures, percent of homosexual preoccupation and percent of homosexual fantasy, as well as the therapist's ratings of outcome were used to determine the effectiveness of therapy. The authors reported that the treatment group improved significantly over the control group on all outcome measures.

In a similar study, Truax and Tourney (1971) used a therapy group of 30 homosexual men and a control group of 20 homosexual men. All clients were self-referred university students. Individuals were excluded from this study if they appeared to be only curious and lacking motivation for therapy. In addition to the measures used in the previous study the authors included such measures as the frequency of heterosexual dating and intercourse, social relations, success in work or school and amount of insight. On every measure except success in work or school the therapy group had significantly improved over the control group after seven months of therapy. More improvement was seen in neurotic symptomotology than in moving toward heterosexuality although this continued to improve with further therapy. Follow-up data on 25 of the clients one to three years after therapy indicated that 20 had remained substantially changed. Eleven of these 20 had continued in individual therapy after the study was completed.

According to Hadden (1966) the advantages of homogeneous groups in helping homosexual persons to change their sexual orientation include group confrontation for breaking down rationalizations and group support for the anxiety that follows. The all-homosexual group can also provide models of people who have achieved some degree of success in moving toward a heterosexual orientation. Singer and Fischer (1967) believed that an exclusively homosexual group provides a supportive and protective setting within which the client can express feelings, emotions and struggles.

Nobler (1972) asserted that group therapy, whether in mixed groups or in exclusively homosexual groups, is superior to individual therapy alone. She believed that both heterogeneous and homogeneous groups have value in breaking down rationalizatons about homosexuality and offer a climate for examination and change of homosexual behavior and lifestyle. She, along with Truax and Tourney (1971), proposed that group therapy may be precursory to individual therapy, allowing clients to make better use of individual therapy after starting in group. Group therapy helps the client to become more aware of his or her impact on others and allows for an overall broadening of involvement with other people.

One very significant advantage of group therapy is that the group can provide support and encouragement in the crucial period between when one leaves the homosexual world

and finds an identity as a heterosexual. This can lessen the client's fear of being caught between two worlds and belonging nowhere (Nobler, 1972). This support may be the attraction of self-help groups for changing sexual orientation that have been forming over the past decade.

Self-Help Groups

Although they are outside of the mainstream of psychology it seems appropriate to include an examination of self-help groups because of the role they currently play in helping people to change their sexual orientation. These groups are self labeled "ex-gay" and are largely associated with Christian churches. Martin (1984) stated several reasons why it is germane to include the ex-gay approach of sexual reorientation in a discussion of therapuetic approaches to ego-dystonic homosexuality. For one, he believed that religion played a major role in creating the social and intrapsychic attitudes that contribute to the development of ego-dystonic homosexuality. Futhermore, the ex-gay movement is offered and advertised as a form of therapy. Thirdly, the publication of an article by Pattison and Pattison (1980) in a major journal describing ex-gay approaches has given the movement respectability as a therapeutic approach.

In this article, Pattison and Pattison evaluated 11 men who claimed to have changed from exclusively or predominately homosexual to exclusively or predominately heterosexual as rated by the Kinsey scale. The subjects

were persons who had contacted a crises program for homosexuals that was offered by a pentecostal church. Of 300 such contacts over a five year period, 30 claimed to have become heterosexual. These claims were substantiated by program staff who knew all the subjects. Eleven of the 30 agreed to an extensive personal interview. For each of these 11 men the change in sexual orientation had taken place in the context of the church fellowship which offered support, acceptance and the expectation of change. Changes took place gradually over time and included cognitive, behavioral and intrapsychic changes.

In a second study Pattison and Durrance (1985) surveyed participants from 20 ex-gay programs in 11 states. These programs consisted of small self-help groups designed for the purpose of helping homosexual persons become heterosexual. Extensive questionaires were sent to these various programs and over 50 were returned with complete details. Two-thirds of these respondents were successful in that they had given up the homosexual lifestyle but they were frank in their admission of continued homosexual orientation in terms of psychological preference. The other 15 of the 50 respondants claimed a complete change in sexual orientation. Most had changed five or six points on the seven-point Kinsey scale. If Pattison and Durrance had required only behavioral change as the criterion of sexual reorientation, all 50 would have been successful. Their more strict definition including intrapsychic change allowed only

15 to qualify.

Problems With Group Therapy Research

Again the main problem is with measuring changes in sexual orientation. With a few exceptions the measures were largely subjective, based only on the client's report or the clinical judgement of the therapist. Usually there was no assessment prior to therapy as to a client's degree of homosexuality other than the client's belief that he or she is homosexual.

Many of the clients were in individual therapy along with the group therapy. This makes it difficult to assess what part of any change that did take place can be accredited to group therapy.

Summary of Group Therapy

Although it is difficult to assess the degree of change that can be attributed to group therapy because of inadequate measurement, it does appear that some significant changes have been accomplished. Although there are different advantages to heterogeneous and homogeneous groups, these differences do not seem to significantly affect the ability of one compared to the other in helping to change sexual orientation. It does appear that in those cases where the designated goal of group therapy is to change sexual orientation, therapy is more successful in reaching the goal. The critical factor here is that the client must be motivated to change, a factor common to any therapy.

Present Direction of Treatment for Homosexuality

Along with self-help groups, another option currently available to homosexual persons desiring to change their sexual orientation is the Masters and Johnson Institute treatment program. This program was started in 1968 to provide treatment to homosexuals with sexual dysfunction and to provide "therapeutic support for selected homosexual men and women who specifically desire to alter their sexual orientation" (Schwartz & Masters, 1984, p. 173). Masters and Johnson's (1979) reported failure rate in helping dissatisfied homosexuals change to a heterosexual lifestyle upon completion of an intensive short-term program was 20.9%. After five years of follow-up the failure rate was 28.4%. Gonsiorek (1981) and Krajeski (1984) criticized the Masters and Johnson study as inaccurately representing the data. Krajeski argued that only a small percentage of the subjects were homosexual according to the figures given. Of the 54 male subjects, only 9 were rated 5 to 6 on the Kinsey scale. The remaining 45 subjects had Kinsey ratings of 2 to 4. Secondly, he criticized them for reporting a failure rate of 28.4% implying a success rate of 71.6%. In actuality only 23 of the 54 subjects, 42.6%, had successfully changed to heterosexuality. However, even if this criticism is accepted, the Masters and Johnson Institute study appears to substantiate that therapy can help some homosexuals to change their sexual orientation.

The Institute program is unique in that it addresses various aspects of the homosexual client's life. Pretreatment counseling aims at improving the patients social, sexual and intimacy skills; creative problem solving; and stress management. Treatment deals with fears and anxieties that arise from an actual heterosexual relationship. Psychotherapy focuses on belief systems, patterns of relating, developing new ways of coping, and developing a lifestyle that builds a positive self-image.

This broader approach to treating homosexuality is consistent with current views of homosexuality. The definition of homosexuality has been expanded to include more than just sexual orientation. Herron et al. (1982) stated that when doing therapy with a homosexual person, the therapist must be aware of the various components of the person's homosexual identity. While sexual orientation is one of these components, sexual identity also includes biological sex, gender identity, and social sex role. De Cecco (1982) discussed these same components when describing what he labeled the "gay identity."

Defining homosexuality has been the major problem in both treatment and research of homosexuality. Until agreement can be reached on a definition, each study will measure change in sexual orientation based on those variables chosen to define homosexuality by each individual researcher. This makes it difficult to compare studies and to determine any consensus about the effectiveness of

therapy for changing sexual orientation.

It has become evident that homosexuality is more than just sexual behavior, a commonly used measure of sexual orientation. Along with other aspects often included in measuring sexual orientation, such as sexual attraction, sexual preference, fantasies, and physiological responses, homosexuality also includes self-identity and lifestyle. Kinsey et al. (1948) recognized that homosexuality was not a singular condition. Kinsey's continuum of sexual orientation included both behavioral and psychological measures. However, because of the subjectivity of determining sexual orientation using the Kinsey scale it has been frequently misused. Often only the behavioral elements of the scale have been used in rating sexual orientation.

In responding to the weaknesses of the Kinsey scale and to the expanding definition of homosexuality, Klein, Sepekoff, and Wolf (1985) developed the Klein Sexual Orientation Grid designed to measure a person's sexual orientation as a dynamic multi-variable process. The grid includes seven variables: sexual attraction, sexual behavior, sexual fantasies, emotional preference, social preference, self-identification, and hetero/gay lifestyle. Like the Kinsey scale, each of these are rated on a seven-point continuum. Also, to deal with naturally fluctuating changes in sexual orientation, as well as the discrepancy between how people see themselves and how they would like to

be, the grid assesses these seven variables in terms of the past, the present, and the ideal perception of one's sexual orientation. While the Klien Sexual Orientation Grid is still relatively new and not widely used, it is a step in the direction toward recognizing the diversity of homosexual persons.

Summary

History of Therapy for Homosexuality

Mayerson and Lief (1965) stated that the earliest therapeutic attempts to change sexual orientation began in the 1940's. These were attempts by psychoanalytic therapists to "cure" homosexuals. By the end of the 1950's accounts of successful change to heterosexuality began to be reported.

In the 1950's behavior therapists joined in the effort to help people change their sexual orientation. Also during this time reports began to appear on the effectiveness of group therapy in changing sexual orientation. Most of the literature on sexual orientation change comes from the period between 1960 and the latter 1970's.

During the 1960's much of the research focused on whether homosexuals exhibited more pathology than heterosexuals. The American Psychiatric Association's decision that homosexuality is not indicative of pathology and the removal of homosexuality from its list of mental disorders in 1973 was a turning point in therapy for homosexuality. People have questioned how ethical the

aversion techniques of behavior therapies were. The issue was raised that if homosexuality was not pathological then maybe therapists should not offer help in changing sexual orientation (Davison, 1976, 1978; Morin, 1977). The focus began to shift toward helping homosexuals to accept their homosexuality and to deal with the pressures of society. But not all therapists accepted the view that homosexuality is an acceptable alternative sexual orientation. This was reflected in the inclusion of a new diagnosis, "ego-dystonic homosexuality," in the DSM III published in 1980.

Current State of Therapy for Homosexuality

Presently little is being reported on therapy for changing sexual orientation. Psychoanalytic therapists who continue to view homosexuality as pathological place little emphasis on changing sexual orientation either to avoid controversy or to follow the advice of Mitchell (1981) and not single out homosexuality but treat it as any other symptom a client may present. Group therapies, largely psychoanalytic in orientation, have followed the same path.

Because of changing attitudes toward homosexuality and criticism of aversion therapy, behavior therapists in the United States have quit attempting to change sexual orientation. There are reports from countries such as India of continued research with aversion therapy (Kaliappan, 1982; Nammalvar, Rao & Ramasabramaniam, 1983).

Although traditional group therapy has not been active

in sexual orientation change, a new form of group therapy, the self-help group, has become one of the main sources of help for the homosexual wishing to become heterosexual. Masters and Johnson offer another source, a short-term intensive treatment program designed to deal with various aspects of the problems faced by persons attempting to change their sexual orientation.

Problems With the Research

Definition and measurement. As has been seen throughout the studies described in this paper, the major problem has been in defining exactly what is meant by homosexuality. Related to this is the problem of measuring sexual orientation and, thereby, any change in sexual orientation. Sexual behavior has been the most often used criterion to assess sexual orientation, perhaps because it is the easiest aspect to change and is readily observable. Behavioral measures of change have been criticized because sexual behavior is flexible and easily modified and may not represent true change in sexual orientation.

Those studies using psychological measures such as sexual attraction, sexual desire, and sexual fantasy are criticized for being too subjective. These criteria by their nature are measured by the client's self report. Also criticized for subjectivity are measures of success based on the therapists perception of change. In some cases these were long-term therapies where the therapist had intimate knowledge of the client's behavior and psychological

responses.

Sometimes physiological measures were used, usually measuring changes in penile volume. While this may be one of the most precise measures used, it has little value in predicting psychological responses or future behavior. Another drawback is that it can only be used for male homosexuals.

Lack of research with lesbians. Most of the research on homosexuality has focused on male homosexuals and their problems. One reason for this may be that male homosexuality has been more visible. When homosexuality was still criminal, it was the lifestyle of many male homosexuals that subjected them to prosecution. Now that homosexuality is no longer a crime and treatment is not coerced, men are still more likely to request help to change sexual orientation. Although self-help groups and the Masters and Johnson Institute program are both available to men and women, it is predominately men that request help from both. Pittman and DeYoung (1971) observed that homosexual persons in ongoing relationships are less likely to desire change, and lesbians are more likely to be in such relationships than male homosexuals.

Can Therapy Change Sexual Orientation?

The literature indicates that with some qualifications sexual orientation can be changed by therapy. Each of the different kinds of therapy have reported success at

changing sexual orientation as measured by sexual behavior. While changing sexual behavior has been criticized as not necessarily indicating change in sexual orientation it is considered by most researchers and therapists to be a major aspect of sexual orientation.

Some studies have found that psychological changes occur through treatment. Homosexual clients have gone through extensive changes whereby they no longer have any desire for homosexual relations and even report exclusively heterosexual fantasies. Pattison and Durrance (1985) compared the process of changing sexual orientation to the Alcoholics Anonymous model. Among both homosexuals and alcoholics, some people may never completely attain their goal although actively attempting to do so. Others may gain control over their behavior but continue to stuggle intrapsychically, needing external support to maintain their behavior. Others may reach the point where they completely lose the desire and no longer need help from others. All of these levels of change indicate success to some degree.

Psychoanalytic therapy. Most of the reports of successful psychotherapy are based on clients' reports of changes in sexual behavior and lifestyle. These changes include social contacts and often reports of happy marriages at follow-up. Some studies reported significant change after an average of four to five years of follow-up (Mayerson & Lief, 1965; Ovesey, 1969). The extended length of psychotherapy allows for a fairly intimate knowledge of

the client by the therapist. This coupled with the extended follow-up of some of these studies strengthen their credibility.

The client's desire to change is emphasized throughout the analytic literature as a major prerequisite to changing sexual orientation. Arlow et al. (1968) and Mitchell (1981) stressed that the motivation must come from the client if change is to be complete and satisfactory to the client. Each homosexual person is unique and must be treated as an individual not as a homosexual.

Most of the analytic studies also reported that persons with previous heterosexual experience had a better chance of success than persons whose sexual contacts were exclusively homosexual. Bisexuals can change more easily than those who are exclusively homosexual.

Behavior therapies. Aversion therapy was successful at decreasing homosexual behavior but did not always increase heterosexual behavior or desire. Classical conditioning was more successful at increasing heterosexual responsiveness. A combination of the two was reported to be effective in changing behavior, physiological responsiveness, sexual desire, and even fantasies. Freeman and Mayer (1975) reported that by using such a combination 9 of 11 men remained heterosexual on these measures after 18 months of follow-up.

While behavior therapists do not directly address

issues of motivation, it is implied that anyone willing to endure aversion therapy is motivated to change. Although follow-up was not done as often or as long as in the analytic studies, in those cases where it was done the conclusion also points out that changes in lifestyle and environment are the most permanent (Freeman & Mayer, 1975; Maletzky, 1977).

Group therapy. In the research on group therapy we are again presented with the importance of motivation in the therapeutic change of sexual orientation. Persons most likely to change were those who began therapy with the goal of changing. In some cases, however, the client began therapy for other problems and chose to change sexual orientation during the course of therapy. Sometimes this was due to group influence to do so. Although this group influence may be seen as pressure to change that conflicts with the client's free choice, it appears to be helpful to the person desiring to change. The group can provide both confrontation of rationalizations and offer support and encouragement during the transition from a homosexual to a heterosexual lifestyle.

Most changes were described as sexual behavior changes although some studies included increase in heterosexual relationships as a measure of change. Compared to the research of other therapies to change sexual orientation, the group therapy studies most poorly addressed the degree of homosexuality of each client and the degree of change

measured.

Clients were often involved in individual therapy at some time before, during, or after the group therapy, confounding the effects of group therapy so that no certainty can be placed on how much the change can be attributed to group therapy. In fact group therapy may best be used in conjunction with individual therapy to change sexual orientation.

Conclusion

The conclusion appears to be that not everyone who wants to change their sexual orientation can do so with the help of therapy. However, motivation to change is a key factor or a prerequisite to successfully change sexual orientation through therapy as is the case in most therapeutic endeavors. As Masters and Johnson (1979) and Pattison and Durrance (1985) pointed out, external expectations and support to change can play an important role in successfully changing sexual orientation. This includes the belief that such change is possible.

Another critical element in determining the chance of success is the degree to which the client is rated homosexual on the heterosexual/homosexual continuum. This is sometimes stated simply that previous heterosexual experience increases a client's chances of becoming heterosexual. This does not mean that someone exclusively

homosexual cannot change, only that it will likely be much more difficult.

The reported success of self-help groups and the Masters and Johnson Institute treatment program for sexual orientation change seems to be due to the support given and the instillation of hope that change is possible. Both also address the broader issues of changing one's sexual identity and complete lifestyle. Those changes in sexual orientation that seem most complete involve a change in lifestyle whereby the person takes on a new social and sexual identity. Kraft (1971) reported on a client who stated at the end of therapy that he had asked to be cured of homosexuality but had no idea it would involve a change in his whole way of living. It is these larger issues of lifestyle and identity that therapists and researchers must more fully address if persons desiring to change their sexual orientation are to be offered the best chance of succeeding.

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